DO NOT WRITE IN THIS SPACE

STATE OF MAINE

DRIVER'S REPORT OF TRAFFIC ACCIDENT

The Secretary of State is reponsible for determining whether an accident is reportable and compliance with the Financial Responsibility law.
This report must be filed within 48 hours of the accident.
PLEASE COMPLETE BOTH SIDES OF THIS REPORT – ANSWER FULLY EVERY QUESTION IN **INK**

MAIL TO: Bureau of Motor Vehicles
Accident Section
29 State House Station
Augusta, ME 04333-0029
(207) 624-9000 Ext. 52110

WITHIN 48 HOURS FOLLOWING ACCIDENT

TIME ▶ DATE OF ACCIDENT _____ Day of Week _____ Hour _____ A.M. ❒ P.M. ❒

DO NOT WRITE IN THIS SPACE

PLACE ▶
PLACE WHERE ACCIDENT OCCURRED County _____ City or Town _____

If accident was outside city limits, indicate distance from city limits of nearest town _____ miles North ❒ S ❒ E ❒ W ❒ of _____ City or Town

ROAD ON WHICH ACCIDENT OCCURRED _____ Give name of street or highway number

AT ITS INTERSECTION WITH _____ Name of intersecting street or highway number

ACCIDENT INVOLVED: ❒ Pedestrian ❒ Bicycle ❒ Other Motor Vehicle ❒ Animal Drawn Vehicle ❒ R.R. Train ❒ Animal ❒ Fixed Object ❒ Other _____

YOUR VEHICLE (No. 1)

❒ **MOVING** ❒ **STOPPED** ❒ **PARKED** **(Indicate last known driver)**

DRIVER LICENSE NO. STATE

DRIVER'S NAME LAST, FIRST, MIDDLE

D.O.B. Month Day Year ❒ Male ❒ Female PHONE NO.

CURRENT ADDRESS, NUMBER AND STREET **Check If New Address** ❒

CITY/TOWN STATE ZIP CODE

PLATE NO. STATE Type (Lobster, Chickadee, Conservation, Commercial, Etc.)

SAME AS DRIVER ❒ **OWNER NAME** LAST, FIRST, MIDDLE

D.O.B. Month Day Year PHONE NO.

CURRENT ADDRESS, NUMBER AND STREET

CITY/TOWN STATE ZIP CODE

YEAR MAKE

V.I.N.

DESCRIBE DAMAGE TO VEHICLE

ESTIMATED COST TO REPAIR

OTHER VEHICLE (No. 2)

❒ **MOVING** ❒ **STOPPED** ❒ **PARKED** **(Indicate last known driver)**

DRIVER LICENSE NO. STATE

DRIVER'S NAME LAST, FIRST, MIDDLE

D.O.B. Month Day Year ❒ Male ❒ Female PHONE NO.

CURRENT ADDRESS, NUMBER AND STREET **Check If New Address** ❒

CITY/TOWN STATE ZIP CODE

PLATE NO. STATE Type (Lobster, Chickadee, Conservation, Commercial, Etc.)

SAME AS DRIVER ❒ **OWNER NAME** LAST, FIRST, MIDDLE

D.O.B. Month Day Year PHONE NO.

CURRENT ADDRESS, NUMBER AND STREET

CITY/TOWN STATE ZIP CODE

YEAR MAKE

V.I.N.

DESCRIBE DAMAGE TO VEHICLE

ESTIMATED COST TO REPAIR

TOTAL NUMBER OF VEHICLES INVOLVED _____ If more than two vehicles were involved, describe the additional vehicles on separate report forms and attach to this report.

As a result of this accident, was anyone summoned to court? _____ Arrested? _____ Or was anyone convicted? _____ If so, who? _____ Name of court _____ Charge _____

Did a Law Enforcement Officer investigate at the scene of the accident? ❒ Yes ❒ No

Name of investigating officer _____ Please Print Department _____ (State Police, Sheriff, Local Police, etc.)

WAS A POLICY OF LIABILITY INSURANCE, COVERING THE VEHICLE YOU WERE DRIVING, IN EFFECT AT TIME OF ACCIDENT? ❒ YES ❒ NO
PLACE YOUR LIABILITY INSURANCE POLICY IN FRONT OF YOU BEFORE COMPLETING THE BLANKS BELOW. IF ANY OF THE BLANKS ARE NOT COMPLETED, IT WILL BE ASSUMED THAT YOU WERE NOT INSURED, AND THE FINANCIAL RESPONSIBILITY LAW MAY BE INVOKED AGAINST YOU.

DAMAGE TO PROPERTY
OTHER THAN VEHICLES _____ Approximate cost to repair $ _____

Name object and state nature of damage

Name and address of
owner of object struck _____

INJURED

Name _____ Age _____ ❒ Driver In vehicle
❒ Male ❒ Passenger ❒ No. _____
Address _____ ❒ Female ❒ Pedestrian

MARK FIRST ONE THAT APPLIES			
1 Killed ❒	2 Visible signs of injury, as bleeding wound or distorted member, or had to be carried from scene ❒	3 Other visible injury, as bruises, abasions, swelling, limping, etc. ❒	4 No visible injury but complaint of pain or momentary unconciousness. ❒

Name _____ Age _____ ❒ Driver In vehicle
❒ Male ❒ Passenger ❒ No. _____
Address _____ ❒ Female ❒ Pedestrian

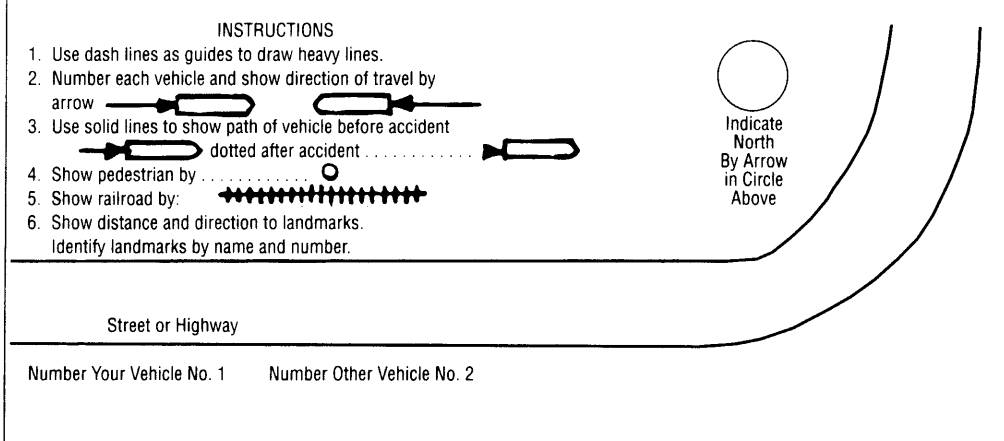
MARK FIRST ONE THAT APPLIES			
1 Killed ❒	2 Visible signs of injury, as bleeding wound or distorted member, or had to be carried from scene. ❒	3 Other visible injury, as bruises, abasions, swelling, limping, etc. ❒	4 No visible injury but complaint of pain or momentary unconciousness. ❒

Name _____ Age _____ ❒ Driver In vehicle
❒ Male ❒ Passenger ❒ No. _____
Address _____ ❒ Female ❒ Pedestrian

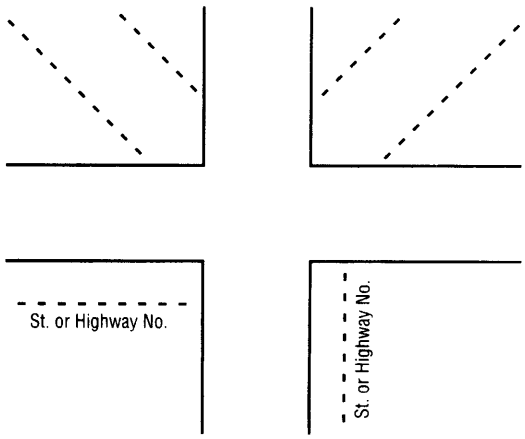
MARK FIRST ONE THAT APPLIES			
1 Killed ❒	2 Visible signs of injury, as bleeding wound or distorted member, or had to be carried from scene. ❒	3 Other visible injury, as bruises, abasions, swelling, limping, etc. ❒	4 No visible injury but complaint of pain or momentary unconciousness. ❒

INSTRUCTIONS

1. Use dash lines as guides to draw heavy lines.
2. Number each vehicle and show direction of travel by arrow
3. Use solid lines to show path of vehicle before accident dotted after accident . . . . . .
4. Show pedestrian by . . . . . O
5. Show railroad by:
6. Show distance and direction to landmarks. Identify landmarks by name and number.



Number Your Vehicle No. 1 Number Other Vehicle No. 2



DESCRIBE WHAT HAPPENED
(Refer to vehicles by number) _____

SIGN HERE

_____ Current Mailing Address _____ Date _____

Signature of DRIVER / your vehicle (No. 1)

FR-1 MAINE

COMPLETE - DO NOT DETACH
INSURANCE INFORMATION

INSURANCE

Name of Company (Not Agency) Which Issued Insurance Policy to Cover Liability for Damages or Injury to Others _____

Company Mailing Address _____

Agent or Broker Who Sold Policy _____ Phone No. _____ Mailing Address _____

Policy Number _____ Policy Period from _____ to _____

Date of Accident _____ (Month / Day / Year) In or Near _____ (City or Town)

Make of Your Vehicle _____ Type _____ Year _____ Vin. No. _____

Driver _____ Date of Birth _____ Mailing Address _____

Registered Owner _____ Date of Birth _____ Mailing Address _____

Full Name of Policy Holder(s) _____ Mailing Address _____

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INSTRUCTIONS TO INSURANCE COMPANY

1. **If the accident described on the reverse side was not covered by liability insurance as indicated, check reason below and return this form dated and signed to the address below.**
2. **If indicated coverage was in effect at the time of the accident no action is required.**

REASON FOR DENIAL:

- ☐ **Coverage does not meet Maine minimum requirements** ($50,000-$100,000-$25,000)
- ☐ **No policy was in effect at the time of the accident**
- ☐ **Driver not covered on policy**
- ☐ **Other (please explain)** _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE	COMPANY NAME/ADDRESS	PHONE	DATE

BUREAU OF MOTOR VEHICLES
FINANCIAL RESPONSIBILITY
29 STATE HOUSE STATION
AUGUSTA, ME 04333-0029 (tel. 207-624-9000, ext. 52108)

✦ DO NOT DETACH ✦